



**Texas Department of Insurance, Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**PART I: GENERAL INFORMATION**

Requestor's Name and Address:  J. THOMAS DILGER JR., M.D. 6718 MONTAY BAY DRIVE SPRING, TX 77389	MFDR Tracking #: M4-09-7140-01
Respondent Name and Box #:  SERVICE LLOYDS INSURANCE CO BOX # 42	

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Provider did not submit a position summary.

Principle Documentation:

1. DWC 60 package
2. Medical Bill
3. EOB(s)
4. Medical Reports
5. Total Amount Sought \$275.00

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary states in part, "The Requestor is seeking reimbursement from the Carrier for date of service September 4, 2007 in the amount of \$275.00 for a Designated Doctor's Examination. At the outset it should be noted that the Provider has not timely submitted this MDR Request. Per Rule 133.307(c), "A requestor shall timely file with the Division's MDR Section or waive the right to MDR." A timely request "shall be filed no later than one year after the date(s) of service in dispute." This request was sent to the DWC on February 24, 2009. The date of service in dispute is September 4, 2007. Therefore, this request was not timely sent...."

Principle Documentation:

1. DWC 60 package

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
9/4/07	150, B15, W1, 105, 145, W4	99456-WP, 96118	\$275.00	\$0.00
Total Due:				\$0.00

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

1. Medical Fee Dispute Resolution (MFDR) received the DWC-60 on 2/24/09. The date of service in dispute is 9/4/07.
2. 28 TAC Section 133.307(c)(1)(A) states in part, "A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
3. This dispute was not submitted timely.
4. The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.307 section (c)(1)(A). As a result, the amount ordered is \$0.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311  
28 Texas Administrative Code Sec. §133.307

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

12/7/09

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

**PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**